

**Capistrano Unified School District**  
San Juan Capistrano, California

**LOW INCIDENCE REFERRAL**

Child's Name: \_\_\_\_\_ Grade: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

School: \_\_\_\_\_ Teacher: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Referred by: \_\_\_\_\_ Position: \_\_\_\_\_

Case Carrier: \_\_\_\_\_ Telephone: \_\_\_\_\_

Area of concern: (check)       Hearing       Vision       Mobility

Please attach a current (within one year) evaluation from the child's:     audiologist     ophthalmologist     optometrist  
*(check)*

Please attach a copy of the current IEP (pages 1 and 2) if the child is enrolled in Special Education. If the child is not in Special Education, describe the current program and intervention to date:

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Please describe your present concerns regarding this student and the assistance/services you are requesting:

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**Send this form and supporting documentation, via DISTRICT MAIL to the**

Special Education Department  
Capistrano USD  
Phone: (949) 489 7100

**Or Fax to:**

Special Education Department  
(949) 240 9047